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HOSPITAL STANDARDIZATION SERIES

REPORT OF HOSPITAL CONFERENCE HELD AT PHILADELPHIA, OCTOBER 24, 1921

AMERICAN COLLEGE OF SURGEONS
40 EAST ERIE STREET :: :: CHICAGO

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REPORT OF THE HOSPITAL CONFERENCE HELD AT THE CLINICAL CONGRESS OF THE AMERICAN COLLEGE OF SURGEONS OCTOBER 24, 1921, PHILADELPHIA[1]

MORNING SESSION—THE PRESIDENT, GEORGE E. ARMSTRONG, M.D., PRESIDING

HOSPITAL STANDARDIZATION, ITS INCEPTION, DEVELOPMENT, AND PROGRESS IN FIVE YEARS

BY FRANKLIN H. MARTIN, M.D., CHICAGO
Director-General of the American College of Surgeons

YOU have all undoubtedly asked yourselves why this program of the American College of Surgeons has been received with so much approval, why it has attracted so much attention, why it has had so much influence.

Scientific medicine is developing so rapidly that of necessity it is reducing the number of the medical profession in proportion to the people they have to care for. Medicine, therefore, is becoming more wholesale and institutional, less retail and domiciliary. That of necessity has placed an enormous responsibility upon the hospital, because the hospitals must be the institutions in which the wholesale or group medicine is practised.

The American College of Surgeons is responsible for the standardization of hospitals, because in its early days it found it necessary to standardize its own environments. For instance, in making a standard for admission to fellowship, it was necessary that we ask the candidates to furnish us the reports of fifty major operations and fifty minor operations, in lieu of an examination. These reports began to come in. They were on all kinds of forms. There was absolutely no standard record on which they could give us the evidence of their own ability to practise surgery. Soon we were asked from every direction to furnish a standardized system of records, to suggest a form upon which these records could be given to the College. We attempted to do that. A committee was formed for the purpose, and we furnished, wherever required, a set of standardized records. Then what happened? The hospitals—a great many of them—began to ask us if we could not in some way furnish these same standardized records or forms to them, which, of course, we were very glad to do.

That was the first step in the standardization of hospitals. Then, early during the war, it became necessary for us to have some other minimum standards that would apply to the hospitals in the camps, the army hospitals. And in Washington was called a conference of medical officers and we discussed a minimum standard for military hospitals.

After that, in one year, the American College of Surgeons formulated its minimum standard for hospitals. Is there anything that a hospital can leave out of that standard and be a hospital? First, records; second, staffs, with staff meetings; third, a competent and honest staff; fourth, laboratories. That is practically the minimum standard of the American College of Surgeons. Any hospital that cannot furnish this minimum standard is not a hospital. It is the very minimum thing we could ask of hospitals to do in order to have us recognize them as hospitals.

That led immediately to a survey of the hospitals to ascertain which hospitals met this minimum standard. For the last three or four years surveyors employed by the College have visited all of the hospitals of one hundred or more beds in the United States and Canada.

SUMMARY OF YEARLY REPORTS

In 1918, of the 692 general hospitals of one hundred or more beds, in the United States and Canada, 89 met the standard; in 1919, 198; in 1920, 407, or 57 per cent; and this year 579 of a total of 764 hospitals, or 75 per cent, meet the standard of the College.

[1]The College assumes no responsibility for any addresses other than those of its officials and staff-members.

1921 REPORT

Today, we have the pleasure of presenting to you our annual report on the hospitals of North America, having one hundred or more beds. This list contains the names of such general hospitals in the United States and Canada as have met the minimum standard. In this list, a certain number of institutions are designated with a star. This group includes those hospitals which, when visited, had adopted the fundamental principles of the minimum standard, but which at that time had not had sufficient opportunity to develop all of them to a degree meriting the fullest approval. The hospitals listed without a star instituted these measures at an earlier date, and consequently received the benefits of a longer experience in the workings of the program and a broader conception of its application.

THE FUTURE PROGRAM

The program of the future will be extended to include all general hospitals of fifty or more beds in the United States and Canada. Of these institutions, many of which have been visited, a large number showed a working knowledge of the minimum standard and evinced an active desire to co-operate. The percentage of these meeting the standard on first visit compares favorably with the percentage of the larger hospitals approved on first inspection. If proof were needed of the universal application of the minimum standard, the acceptance by the smaller hospitals would furnish it. Stressing only broad fundamentals, the minimum standard molds itself to meet specific needs, nowhere impeding initiative or fettering judgment. Rightly conceived and carried out, it makes the hospital the proved guardian of the community health, rendering scientific service to all.

WHY THE COLLEGE MUST CONTINUE THIS SURVEY

Now, surgeons and hospital superintendents, what is the future program of hospital surveys other than I have indicated here? Why should the American College of Surgeons continue this work? It should continue the work because it is the measure that the College has of the fitness of the men who we expect will enter the College. It is impossible for the College to do anything but to take the leadership in the question of its own standard. It is something that we cannot delegate to someone else. Therefore, as long as the American College of Surgeons is in existence, I can see that it will be the duty of the American College of Surgeons—duty to itself—to see that the environment in which its candidates do their work is of the proper kind. Therefore, this work will have to go with the College. The success of this work, I believe you will all realize, lies in the fact that back of it is a great ideal for service and honesty. And this is the reason the program has succeeded far beyond our expectations.

HOSPITAL STANDARDIZATION FROM THE VIEWPOINT OF THE MEDICAL PROFESSION

By ROBERT L. DICKINSON, M.D., New York

MILD as this meeting looks, Mr. Chairman, it represents a revolution that has come very quickly and very sanely. Years ago Dr. Codman asked of the medical profession and of hospitals: "Do you dare show us your end-results?" A Dr. Martin takes up this challenge and with a Bowman and a Moulinier puts it into effect, and in working order, on a surgically sane basis. Hospitals have been answering that challenge ever since and their answer to the challenge represents the effect of hospital standardization.

Hospital standardization might belong to the American Hospital Association, that wonderfully able body represented here so fully. But standardization of the surgeon belongs to the surgeon.

Now, Codman saw years ago that you can have a surgical accounting as you can have any accounting. If it could be done in government, if it could be done in finance, it can be done here. Honor, honesty, and efficiency can be measured.

Let us come to the staff review. I take it the College—I am not speaking officially for them—I take it the College has had this to say: "Yes, we can give you a sample laboratory list, but as to what constitutes a staff review, you had better experiment a while yourselves. Start the machinery. Try it out." I think the time has come for the College to give us a sample procedure for staff meetings, adaptable to different types of hospitals.

One other pitfall: Here is a surgeon knowing that he should not have a mortality in his active service, we will say, of more than 4 per cent, and who therefore refuses to endanger his mortality record by certain operations. I do not want

any man to refuse to open my abdomen because he might exceed his death-rate. You have to have fearless surgery today.

Now, on the other hand, the reckless experimenter with human life must be curbed. Some of the greatest surgeons are the most reckless. How are we going to take counsel in any of these great things unless we do as Codman has told us to do? We should charge up an error of judgment or of technique when indicated and, in other cases, wipe that physician's record clean from censure who operates upon a patient *in extremis*, hoping to save a life. In other words, this matter of fair surgical mortality must be formulated and I think the College is the authority to act.

The hospital trustee comes to me and says: "You know my interest in this matter. What should our records be? What is a fair mortality? What is a fair infection in clean cases?" The College has given us certain averages. What would be a normal average? This is another place where the College might compile and publish interesting suggestions. In my opinion, the time has come to define a few other minimum standards.

Another point regarding the staff meeting: It should be for mutual stimulation and encouragement. Nothing is gained by turning it into a fault-finding clinic. We must bring in individual triumphs, as well as failures. Then the staff meeting will make for better effort.

When all is said and done, gentlemen, the whole story comes down to this: You cannot legislate these things. As the last speaker has said, the answer to all progress in medicine depends upon the elimination of the unfit, and the development of individual honor and competence.

THE HOSPITAL SURVEY OF THE COLLEGE IN 1921

By FREDERICK W. SLOBE, M.D., Chicago
Hospital Standardization Department, American College of Surgeons

IN January of this year, when the hospital program of the College for 1921 was evolved, it was decided to limit the survey to thirty months of hospital visiting. This was from necessity rather than from choice. Consequently, hospitals which were fully approved in 1920 were not revisited this year. Follow-up visits to these hospitals, however, were postponed only temporarily. Particular attention was directed toward those hospitals which either were not on the approved list last year or which were listed with an asterisk. In addition, as many as possible of the fifty-bed hospitals were visited also.

The survey was conducted through personal visits by a corps of seven hospital surveyors. These men—all physicians—were from medical schools and hospitals of widely separated sections of the country. They were given a course of training at the College headquarters, followed by survey work with experienced hospital visitors. This uniformity in training assured the College of uniform reports, which constitutes one of the essential features of the College program. Whether a hospital were in Maine, therefore, or in California, each institution was visited and surveyed on the same basis. Further, by visiting a large number of hospitals scattered over a wide range of territory, these surveyors obtained a general, rather than a local view-point. This policy of personal visits by relatively few, uniformly trained hospital surveyors is one of the most important elements of the College program.

There are certain difficulties experienced by hospitals in their endeavor to meet the standard of the College which merit special emphasis.

Relative to staff organization, one of the chief difficulties seems to be the adoption of a type of staff meeting which actually analyzes the clinical results. Slowness in developing a co-operative, group spirit among the physicians seems to be the chief hindrance. As this spirit develops, the purpose of the staff meeting becomes more nearly realized. In the average hospital a combined staff meeting is essential. Teaching hospitals, however, and other hospitals with highly specialized staffs, and hospitals having a staff membership of only one or two physicians, form certain exceptions to this rule. In such instances, departmental conferences, teaching clinics, and individual analyses take the place of the combined staff meeting.

The adoption of an official resolution prohibiting fee-division has been a second stumbling block in many hospitals. Hospitals which have been slow to respond may be divided into two groups. In the first group are institutions, in which, apparently, the practice has not been unknown and where, consequently, difficulty was expected. It was a distinct surprise, however, to meet opposition to passing such a resolution in

some hospitals of the second group, having a high ethical status in communities or sections of the country where the practice of fee-division is practically unknown. Some of these hospitals were very hesitant about passing resolutions condemning the practice. When they began to realize, however, that they served as powerful examples for other hospitals in which the practice was prevalent and that the College must apply a uniform policy toward all hospitals, they responded. That the viewpoint and stand of the College in this matter is amply warranted is evidenced by the impression gained by our hospital visitors, that the practice of fee-division is present to some extent in nearly every state and province, even though it may be practically unknown in some sections.

Case records are improving steadily although they still constitute the greatest difficulty in many hospitals. Two factors stand out most prominently in impeding the development of proper case-record systems in hospitals: first, the lack of proper interest in the case records by physicians and hospital executives themselves; second, the lack of internes. The first is just as important as the second, because even a full quota of internes without sufficient supervision will often fail to secure adequate records. When the hospitals do their share in supplying sufficient record facilities and personnel, and the staff members co-operate by exhibiting proper interest in supervising the records, most of the difficulties in this connection will be solved.

Laboratories have shown a similar steady improvement. There is a demand for laboratory equipment, technicians, and pathologists, which has been hitherto unknown. One handicap to the development of adequate laboratory service is the system of making a separate charge for each laboratory test performed. This difficulty has been obviated in many hospitals by establishing a flat-rate fee to include most of the usual laboratory tests. Tissue examinations should be included in this flat rate, otherwise it is difficult to obtain routine examination of all tissue removed at operation. Although the flat-rate fee may not be applicable in all hospitals and may be inadvisable in some, it has been of tremendous help to many hospitals in solving their laboratory problems.

Last year, out of the 704 hospitals in the United States and Canada having a capacity of more than one hundred beds, 407, or 57 per cent, were on the approved list. Of that number 193, or almost half, were listed with an asterisk.

This year, the total number of one-hundred-bed hospitals has grown to 764. Of this number 579, or 75 per cent, are on the list. Of these 579, 18 per cent, are listed with an asterisk, showing the great relative decrease in the number of hospitals listed with an asterisk this year. The asterisk has been used to indicate those institutions which, although they have instituted measures adopting the fundamental principles of the standard, have not developed them to their fullest efficiency at the present time.

Besides these larger hospitals, 704 of the fifty-bed hospitals were visited during the past 2 years. According to our records, there are about 875 of these hospitals, leaving about 150 which have not been visited. It is the hope of the College to visit all of these smaller hospitals next year, so that they may be included in the next approved list. The total number of hospitals visited by our hospital surveyors this year is 1,007.

The attaining of the minimum standard, of course, is not purported to be a resting place in the pathway of a hospital's progress. It is no ultimate standard. There are many things beyond. A safe foundation, however, is the first essential. With the basic fundamentals efficiently established, further advance is inevitable.

HOSPITAL STANDARDIZATION FROM THE VIEWPOINT OF THE HOSPITAL SUPERINTENDENT

By ALFRED K. HAYWOOD, M.D., Montreal
Superintendent, Montreal General Hospital; Representing Canada for the American Hospital Association

MODERN hospital administration has become a specialized profession within the past twenty years. Hospital administration today is not only a science, but a business. Those of us who have been hospital administrators for years realize that we are only at the beginning. Our hospitals stand for two purposes: they teach and they heal. It is not possible in every community that every hospital be a teaching hospital, but each one must be a healing hospital. If we hospital administrators are going to take our place in the community without a pretense, when we go out to financial men for aid, we must be in a position to show them the result of our work in black and white. We must prove by results that we are entitled to public confidence and support.

This procedure places a certain increase in expenditure on the hospital administrator. There was a time when we were quite content with a written report of an operation. But now we are not content with that. The majority of the reports are not legible. We must have a typewritten report. That means an extra stenographer and typewriter and extra equipment, and I can assure you that anything done to get 100 per cent of hospital standardization, as we have tried to do it, has meant increased expenditure to the hospital. But I can assure you, in addition to that, it has given us 500 per cent increase in results. A record for which we spent a thousand dollars a year was not worth 10 cents when 5 years went by, and we couldn't use it. Certainly the money we spent on records heretofore was absolutely useless. Now, we can get our records at any time and they are logical and contain every detail. We are considering putting in additional equipment and when the time comes that one of our surgeons seeks information we hope he may make use of it.

RECORDS—HOW LONG SHALL WE KEEP THEM?

This brings up the question, "How long shall we keep our records?" That has bothered a great many of the administrators of our hospitals. You cannot admit seven or ten thousand patients a year and keep a full record of all of them and expect to be able to house such records with the quarters that are available.

If our records are to be of the use they are expected to be, we cannot turn the patient out of the hospital without a very beautifully kept history. We turn our patient adrift as cured without the further knowledge at some late date whether or not the time and money spent on the cure of the patient will be lost. That consequently brings up the follow-up system. It is almost impossible for us to know that a patient has had proper treatment unless we use the follow-up system. And to conduct a follow-up system properly costs a great deal of money. As a rule that does not matter to the surgeon and to the attending men of the hospital.

The more a hospital administrator understands the difficulties of his attending staff, the more willing will he be to provide the staff with material or equipment to meet the hospital standard or for any other purpose that might be necessary. For that reason hospital standardization has indirectly brought the attending staff and the hospital administration much closer together.

STAFF MEETINGS

I think it has been conclusively proved that staff meetings properly run can be of immense benefit to the patient—to the patient first, because that is the ultimate object of our hospitals—and to the attending staff, second. How staff meetings are to be run is a question of opinion. One hospital superintendent says it is best to serve luncheon in conjunction with the meeting. When this is done fewer members leave the meeting for they hear things discussed with less loss of time. I have tried that plan myself and I find it has worked out wonderfully well.

If staff meetings are advantageous from the standpoint of our hospital administrators—and I am sure they are—and if staff meetings are a good thing for the attending staff and a success, why not let us have staff meetings for the rest of the hospital, for the matron of the training school, for the chief engineer, the housekeeper, the fireman? Why not have them meet and hear one another's troubles? They are all spokes of the same wheel, and I am convinced that the results of such meetings would be 100 per cent beneficial. There is no reason why the chief engineer, for instance, should not know something about what

is going on in the hospital. If such meetings are held, you will find that you have a spirit of cooperation among the workers, they work together, not against one another—a condition we used to see so often.

AUTOPSIES

Hospital administrators are anxious to have as many autopsies done in the hospital as possible. I think it is safe to say that the hospital administrator takes more personal interest in the securing of these autopsies in very many cases than the attending man.

Consent for postmortem examination can be secured, and I have been waiting for many a long day to have this opportunity to tell you just what we have been doing in the Montreal General Hospital. I am not doing it myself. I have nothing to do with it, but a member of my administrative staff has. Last year we secured permission for postmortem examination in 86 per cent of all deaths in the hospital, and this year to date we have secured permission in 87 per cent.

Hospital standardization brings to the administrator of the open hospital—I am not speaking on behalf of or against open hospitals—a controlling weapon over his attending staff. It does not necessarily need to be used as a weapon. But this much we do know that in open hospitals the work has not been of the same caliber as the work done in closed hospitals. The hospital administrator today in the open hospitals has in his hands with the aid of his committee of management a means, we will not call it a weapon, whereby he can come before his attending staff and tell them that they must meet the conditions contained in the minimum standard. He can say to them: "Yes, we will give you an open hospital, but in order to derive any benefit from this open hospital, you must meet our minimum standard."

HOSPITAL STANDARDIZATION FROM THE VIEWPOINT OF THE HOSPITAL TRUSTEES

By NEWTON E. DAVIS, D.D., Chicago
Executive Secretary, Conference Board of Hospitals and Homes of the Methodist Church

I COME to speak to you not from the standpoint of a trustee of a hospital but from the standpoint of the executive secretary of the Board of Hospitals and Homes of the Methodist Church which during the past year has had for its distinct service the program of standardizing its hospitals, making a survey of all the institutions within the bounds of the Board and seeking to find out the exact facts in relation to all of the work in our various institutions, especially of the church with which I am affiliated.

Up until a year and one-half ago, the hospitals operating under the Methodist Episcopal Church had no connection whatever one with the other. We had no Board. Since that time a Board has been organized, and the very first question that came before us for consideration was: "What standard shall we adopt and put into effect in regard to our hospital work?" There was only one answer to that—the minimum standard adopted by the American College of Surgeons. That is the best there is at the present time. Whenever we do see a better plan than that adopted by the American College of Surgeons, we shall add that to our already adopted program.

BOARDS OF TRUSTEES

In making a survey of our hospitals during the past year, 65 operating institutions, we have to begin back with the board of trustees, and we find some very interesting facts in our survey. Now, there are four kinds of boards of trustees, inasmuch as there are State institutions, municipal institutions, private institutions, memorial in character more or less, and also institutions operating within the bounds of some one of the denominations. So we have practically four kinds of boards of trustees. The State hospitals deal with their trustees through their State-appointed officers and trustees; the municipal hospitals, through officers and trustees appointed by the municipality; and the private hospitals are largely run by physicians with particular objectives in mind, memorial hospitals being private hospitals which have been built as memorials for families or for a group of people. We have different objectives in each group.

Now I will take up our own church hospitals. For instance, in an organized society, we have a body of men, the laity and missionary people, who want a hospital and want the church to get back of it. The important objective of any of these hospitals is the same, that is, that the patients shall have the very best kind of service rendered to them, from the diagnostic standpoint, the standpoint of treatment, or whatever it may be.

When we come to the standardization program, one of the first things that we find is that we have

to standardize a lot of boards of trustees. There are as many and varied kinds of ideas among boards of trustees as to what is the standardization program of the American College of Surgeons as there are among some other classes of folks who are non-medical practitioners. And we have had some very interesting sessions with men who for years have been president and secretary and treasurer of boards which have had very little to do with the hospital program. We have had this question asked many times: "Who are you? What does this mean anyway?" Most of them think it means expenditures of money, and it does. But without expenditure of money, we can never get to any place in the world. And I have been very frank to say to these members of our trustees: "You have run the institution on a cheap plan and you will have a cheap result." It means that you will have to expend more money and the best results cannot be secured without putting into it an adequate amount of money. And the boards of trustees of many of our institutions are very unconscious of the fact that none of our institutions can turn out the best product unless they provide conditions which are favorable.

CO-OPERATION OF TRUSTEES AND STAFF

So we face this problem. Many of our trustees have never been in close contact with the staff. They do not know what the staff wants to do. They do not know what a case record looks like. It is absolutely unreadable to them. And so you must educate the board of trustees to know what a really readable chart is and what kind of an analysis should be made in order that patients should have the very best means of diagnosis and the very best service rendered them.

FINANCIAL INTERESTS

Another feature directly concerns the Board of Trustees. They are tremendously interested in the financial interests of the hospital. I know one instance where a board of trustees had notes at the bank amounting to fifty-five or sixty thousand dollars, they were running behind in their current expenses, they did not know just how to meet them, or where they were going to get the money to buy all the equipment that the hospital was calling for. The proposition came up of a new staff organization in the hospital, which would entail the expenditure of an additional amount of money. Could they afford to add additional expense to the already great burdens in order to establish a standardized staff? And in organizing that standard staff, the plan was to determine and specialize the entire staff development. And the president of the Board of Trustees said frankly, after he had been in close contact with the chief of staff: "We cannot afford not to put in the additional equipment, to put in all the standard requirements, regardless of the extra expenditure of money that it does entail!"

Another instance: here is a hospital with a board of trustees which during the past years has not been making any reports to anybody. They have not been responsible to anybody. This board of trustees has been a unit in itself as a hospital, not making a report to any city or State. But somebody else comes along—the American College of Surgeons—and says to the surgeons of the staff: "You do not meet the requirements." A man from the outside steps in and says: "Can we see your hospital records? Can we examine your laboratories and equipment and see what you are doing?" If the surgeons and physicians in your community are to be held responsible for the results of their services in the institution, then the responsibility for that must come back to the board of trustees and also to the people outside who furnish the money to keep the institution going.

LAYMEN PLEASED WITH PROGRAM

We started in to adopt the whole program and the result has been that the boards of trustees are doing their duty toward their institutions and toward the community; whereas a year and a half ago they were letting the staff attend to responsibilities; today they have a larger view of their problem, and a more intelligent appreciation of the work that the institution is trying to do for the City, the State, and the Church.

There is one more word I want to bring to you. I believe that the body of laymen throughout the entire country are tremendously pleased with this great program. Why should they not be? As business men asking for the best results, they could do no better than adopt the program of the American College of Surgeons. A man can only sell something if he has it to sell. He cannot sell what he does not have in the shop. So the doctor who says, "I can do certain things," but cannot produce the goods does not last very long. We have had some non-medical practitioners who have said: "We will close your doors unless we can bring in our patients, regardless of your rules and regulations." The State can hold the board of trustees responsible to the State. They have not gone that far yet. But the State has a responsibility as to what the board of trustees

does, and the responsibility for every case that comes into the hospital comes back to the trustees in the end. If that is so, then the other truth is self-evident that no board of trustees can allow practitioners to come into the hospital who cannot give proper diagnosis or proper treatment or do proper service. They must meet the requirements. And I am sure I speak this morning for a very large number of people and a large number of institutions, and I am very glad, indeed, that the doctors of the American College of Surgeons have made up this program during the past 3 or 4 years and have established a standard. Dr. Martin has been the life-saver for hundreds of physicians.

In closing, so far as our own institutions are concerned, we intend to stand by this program and see that it is put into effect.

THE RELATION OF HOSPITAL STANDARDIZATION TO LABORATORY SERVICE

By JOHN M. BALDY, M.D., Philadelphia

DOCTOR Haywood, who spoke just before Dr. Davis, had a thought which I would combine with what I have to say and with what Dr. Davis has said. And that is the thought of a club over the medical men. I have never liked to admit that to myself but I have not seen it realized in hospital administration. That is exactly what it ought to have. There are enough men who need a little jogging. Can you hold a club over medical men? The whole question of hospital standardization is utterly hopeless if medical men cannot be whipped into shape to see that it is applied in every department.

The second thought is: The trustees lie down on the job, allow their names to be used and abused, and perhaps know nothing about their actual duties.

Now, as bearing on the laboratory and as far as the laboratory is germane to these thoughts, it is just this:

The boards of trustees have no better club, the boards of trustees have no better source of information, as regards the competency of their staff, as regards the earnestness and honesty of their staff, as regards the obedience of their staff to the rules and regulations of the hospital, than is furnished by the laboratory. Do these men in business take things for granted and receive no reports? I do not believe they do. They would not be the successful men they are if they did. And they would not be wanted by the people of the community to head their hospital organization because they are not getting reports of their business. Then why should they not ask to have systematic reports from the heads of this organization? If the board manager will say to the staff, to the superintendent, to the pathologist, etc., that every month he expects to have laid on his table reports of exactly what has been done in each department—so many tests for typhoid, etc.—and if in addition to that the name of the physician is placed opposite the number of the case, it will mean something. You will find that one man in the surgical department has asked for a hundred tests and another has asked for three. The first time that happens—very well, we call attention to the contrast. And the second time, it grows into a serious conference and the surgeon is told that this hospital board expects every man to do his duty; we do not like the looks of this contrast; this laboratory costs money, we have expended money on it; we want his record to show as well as Doctor Smith's—who has a hundred, while he has three; it must be corrected. And the third time: "We are sorry but we want your resignation." And you have to ask only one man on that hospital staff to resign. And if you want to get something out of your laboratory, the young man just out of college looking for a field is the man you can depend on. I would like to call attention to the fact that that is one prime duty of the pathologist, to check up you medical men, and that applies to all the medical staff. If he is a man of the proper caliber, if he is educated to the fact that that is part of his duty, if he is educated to have tact and not to lead his colleagues in the wrong way, they will be glad to have his counsel. He is there not as a technician. He is there as a consultant.

And I say to you boards of trustees by this system you can tell what every man can do. You have it in the laboratory, you have it in the record system. Every hospital should have an historian. I mean an employe, call him what you choose, whose prime duty is taking care of the records and rejecting absolutely every sheet that comes in improperly filled out.

THE STANDARDIZATION PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS

By Rev. CHARLES B. MOULINIER, S.J., Milwaukee
President, Catholic Hospital Association

THIS is the first time I have been put down on the program to present the plan of the American College of Surgeons. And yet I think, during the three and a half or four years that I have been co-operating with the College, I have always been talking on that topic.

You have heard already what are the requirements of the standard. You have heard a great deal about organization of the staff, about the records, about the laboratories, and the division of fees, and about the autopsy work. I shall not go into any technical details because they have been set before you by those who have technical knowledge. I shall try to present to you, in as few words as possible, what seem to me to be the great historic facts of this movement for better hospitals—the scientific fact that underlies it, the ethical basis of it, and its bearing on the religious thought and feeling and spirit which is inevitable.

Historically, the Council on Medical Education began this movement for better hospitals when it began to make the medical schools better and when, following that wonderful movement, it began to look to the interests of the interne some 8 years ago. Some 5 or 6 years ago, the American College of Surgeons, stirred down into the depths of its soul, began to realize that it had a mission for the better care of the sick in the United States and Canada and made up its mind, as you all know and have been told, to improve surgery. But everybody also knows that you cannot improve surgery unless you improve everything that centers in the work of the hospital. And so the American College of Surgeons had not gone very far with its efforts and purpose to improve surgery when it realized that it had to improve everything in medicine.

Knowing that the Council on Medical Education had begun this work, the College, in its fine spirit of honor and regard for the professsion, went and said: "This is what we want to do; what are you going to do?" And the reply was: "Go on and do your work and we will stand by and help you." Therefore, you members of the American College of Surgeons, take it down deep into your hearts that you have been doing a wonderful work for the whole profession in bettering hospital service to the public.

That is the historic fact—absolutely unquestionable because I know it from personal experience in the movement from the very beginning, and hence I always take an occasion like this to say: "All honor to the American College of Surgeons." And furthermore, they are in the middle of the work. It is well begun. They have gone on, let us say, toward the middle of it and they must carry it on to the end, because they are the only body of people as far as I can judge, capable of finishing the movement, at least up to that point where it is sure and safe and sound and destined to go on. That is the historic point of view.

Scientifically, it seems to me that this should be said: The mind of the medical profession is being reached as it was never reached before, to make it more keen, more analytical, more cautious, and more co-operative in its scientific combination of thought, in its analysis of assembled facts, in its careful, gradual, step-by-step arrival at a diagnosis. And this grows out of the organized staff. This grows out of the monthly staff meeting, or weekly departmental meeting, as the case may be. It has brought about that the medical profession working in the hospital has come to the conclusion that minds must get together, that facts must be assembled, and the right analysis of those facts arrived at either by the individual, a small group, or the whole staff. In other words, gentlemen, without intending it, as I observed throughout the continent, the medical mind is being convinced by this program of yours that the time for independent and separate and distinct and hostile personal thinking is past in medicine. Today everybody is convinced that no medical thought is finally safe for the patient, for the public, until several minds have agreed. Standardization, therefore, in as far as it means organization of staff, in as far as it means monthly conferences, has meant a great development of the medical mind throughout the country, and, above all, a great development of medical character. Men today, instead of being distinct individuals, are growing into the greater stature of men working with their fellows, an embodiment of much greater capacity and character communicated into action.

Just one more word about these monthly conferences. I believe there is an incomplete ap-

preciation of what they mean. The College speaks of them as clinical conferences, as investigating the clinical experiences of the hospital. But the College does not say, except impliedly, that in these monthly conferences lies the secret of the success of the whole movement. Your records will not amount in value to the paper they are written on, your laboratories will be useless, you will get no autopsies worth while, the unjust division of fees will go on, unless your monthly conferences are genuinely, are sincerely, are absolutely high-minded and get down into the very heart and soul of every man. Because, gentlemen, what is the monthly conference? It is a review of what was done at the whole institution for every patient that came into the hospital. I do not care how many statistics you have, how correct they are, the facts in figures are without the scientific soul of the facts, unless the soul of the medical man is big enough to analyze those facts. Thirteen deaths in the past month means nothing. Why did each one die? So many unimproved in the hospital means nothing. Why are they unimproved? What has been the use of the laboratory? Why haven't we had more autopsies? Gentlemen, it is hard, it just tears the soul out of a medical man to have to face his own failures, his own incomplete work, his own missing of diagnosis, his own failure to have consultation when he should have had it, his own incapacity to assemble the great facts involved in the case and then miss in his diagnosis or fail in his operation or somewhere in his treatment. They call it a minimum. I call it a fundamental.

And here let me make a plea, such as was made here on the stand this morning, for the young man, for the man that wants to grow. Let the older men play the big brother. Let them be the outstanding leaders, not so much in what they know or in their skill but in their greatness of character, in their readiness to say, "I don't know, I failed, help me."

Now, just one more word on that question of the monthly meeting. The American College of Surgeons has a mission. There is an apostleship for them to take. They have not been brave enough. They have not been aggressive enough. They have not in all cases set the great example of genuineness in these monthly meetings. Those monthly meetings cannot be like the County medical meetings or those of any special association and at the same time attend to the business of the monthly meeting. What has been done for our patients? Where have we failed? Where have we succeeded? Papers, discussions, cases are not the real thing in those meetings. There is no intention on the part of the College to displace County medical meetings, to displace the work of your specialist society, which is all one thing. What has this hospital, from top to bottom, from engineer to superintendent, including the nurses, the orderlies, and everybody—what have we done for our patients during the past week or month?

The College started with the thought of bettering surgery. They are in the midst of bettering the whole practice of medicine. Why? Because the heart of the movement, the heart of the record, the heart of the monthly meeting, the heart of the service in the laboratory—I mean scientific heart and ethical heart—is diagnosis. It all centers on diagnosis; no hurried, no snapshot, yet no elaborate (beyond human frailty) diagnosis, but a genuine, sincere, a definite, direct, cautiously and deliberately arrived at diagnosis of what is the matter with the patient. That is the heart and soul of medicine.

Here again I would like to say a word of commendation, a word of praise, a word of congratulation to the members of the American College of Surgeons throughout the country for the thoughtful, the really scientific, and the deeply conscientious way in which they are going at this program. There is no doubt about it, gentlemen, if I am at all safe in my conclusion on the reading of medical history, that there has never occurred a movement equal to it in the past history of our race. Here we have a great body of men on a great continent—and it is sure to reach the rest of the world—facing a tremendous ethical responsibility by a keen administration that is scientific of the laws of health. It is done because you all, down deep in your hearts—and particularly is it true of the hearts and minds of those men who have led the movement, Dr. Franklin Martin, Dr. John Bowman, and others in the office who have led the movement—feel that it is the greatest in the history of medicine.

If I may be allowed just a few more words: At the first meeting you had in Chicago, when you began this plan, I was fortunate enough to be asked to address you. There were there three hundred members of the American College of Surgeons and the title of the program was "Hospital Standardization." And I can recall with a great deal of vividness that at the end of the morning program I arose and I said: "Gentlemen of the American College of Surgeons, your title may be all right but I am going to be bold enough to say to you that it means not primarily standardization of hospitals but it means the standardization of the medical profession, in mind, in character, and in heart."

REPORT OF RECOMMENDATIONS OF THE AMERICAN RAILWAY ASSOCIATION IN CONNECTION WITH HOSPITAL STANDARDIZATION

By DANIEL Z. DUNOTT, M.D., Baltimore

I HAVE been requested to speak to you this morning on what the railroads have been doing in connection with this program of standardization. And in order that you may form some idea and reach some conclusion as to just what we will be able to do to assist in this movement, I think it might be well to spend a minute or two on the question of what the organization is that I am speaking for.

The American Railway Association is an organization made up of the presidents and managers and operating officials of the various railroads throughout the country that are members of this Association. The Association membership comprises about two hundred and eighty-four thousand miles of railroad in the United States and Canada, and you will therefore see that practically every railroad in the country is a member of this Association.

The Association itself is conducted in the following manner: It has its own president and its general secretaries and secretaries of sections. The operating officials of the American Railway Association, the men who pass upon the recommendations made by the various sections of the Railway Association, are the general managers and the president and vice-president of the railroad, and while the action of the American Railway Association itself is not compulsory or mandatory, it becomes a forceful action as a recommendatory practice because the very men who are called upon to accept the recommendation of the American Railway Association are the men who have favored such action.

The American Railway Association has numerous sections. It is needless for me to go into details in regard to them. Our section is the medical and surgical section and this section comprises, or is made up of, the railway and surgical chiefs of these various railroads that are members of the Association. This section was first incorporated in the American Railway Association about a year ago. And one of the first actions of the committee of that section was to take up the question of hospital standardization, because the railroads felt that it was imperative that our employes injured in service must get all possible care and attention.

The committee on hospital standardization discussing this subject made the following recommendation through its chairman, Dr. A. F. Jonas, of the Union Pacific Railroad:

"The medical and surgical section committee on hospital standardization held a meeting at Chicago on April 6, 1921. In accordance with its understanding of its purpose, it has adopted the minimum standard as the basic recommendations for the railroads of the Association."

The recommendation of the committee was accepted and it was submitted to the various members of the sections, who unanimously approved it and on the sixteenth of November it will be submitted to the annual session of the American Railway Association, and I have no doubt in the world will be approved.

Now, this will mean that the railroads through their surgical service will take the position that they will have their men treated in hospitals that meet with the minimum standard of the American College of Surgeons. You appreciate as well as I that a large amount of our work is of an emergency character and that, therefore, we cannot always be choosers. There will be times when we will have to put men in a hospital that has not adopted the minimum standard for hospitals. But it is our intention wherever it is practicable to remove those patients from such hospitals and put them in a hospital having the minimum standard just as soon as consistent with safety to the patient. I do not know but what it is a pretty good thing to follow that up even a little bit closer than that. I am sure that in a number of instances the transportation of a man seriously injured—crushed leg, we will say—for a greater distance to a better hospital would be giving that man a greater opportunity for recovery than putting him in a hospital that was not up to the standard in its work.

GREAT IMPULSE TO STANDARDIZATION MOVEMENT

We have in the railroads about thirteen thousand doctors and students acting in the capacity of surgeons for the railroads. And we have about 275 or 280 men who are members of

surgical staffs. And with the railroads taking this position, I believe that it will be a tremendous factor in assisting the bringing of standardization over a larger field.

I cannot give you the exact or even the approximate number of hospitals that are used by the railroads. I hoped to be able to get that but I could not. I know that the Baltimore and Ohio uses about 310. The Pennsylvania railroad uses about 277 hospitals. The Union Pacific, on the other hand, a railroad of about nine thousand miles, or three thousand four hundred miles larger than the Baltimore and Ohio, uses only about 123. The Union Pacific has 20 hospitals that are under its own control, at least that they contract with. The other hospitals are hospitals that they have used from time to time in emergency.

The railroads use four-fifths of the hospitals of the country, and while of course a large number of the hospitals have already reached the minimum, still there is a very large field which will be affected by this position of ours, and I can assure you the doctors of the American Railway Association are going to take the position not verbally but actively.

THE INDUSTRIAL HOSPITAL

By EDWARD MARTIN, M.D., Philadelphia
Commissioner of Health, State of Pennsylvania

SHORTLY after our last election in Pennsylvania, in talking with the attorney-general, I said: "The woman's vote has not been conspicuous for its power." And his reply was, "Doctor, there ain't no such animal as the woman's vote." And so in regard to the industrial hospital.

With some exceptions in some localities and in some businesses, I think, and my belief is, that there "ain't", or should not be, such an animal as an industrial hospital. The problems of industry are the problems of civil life.

We see much of special courses in industrial surgery. The basis of industrial surgery is the fundamental medical education, a long training under the eye of an expert, and that training that fits men for surgery in general.

Each industry has its particular form of accidents and each industry must have special experience in that line, and a school of industrial surgery cannot be established in Louisiana, Pennsylvania, or even in Massachusetts, but must be based on that sound, fundamental, surgical knowledge acquired by elbowing or being with a master of his craft and then further knowledge in the individual industry concerned.

And the same holds true, since we are speaking of hospitals, on the medical side.

The answer to industrial surgery would seem to be comparatively simple. There are some people who are obsessed, who are possessed, who are enthusiastic, who are—we will say—crazy, in certain directions. They are the people who lead the progress of the world. Who of you, going back to your school days, going back to your graduating period, who of you would accept any full-time position with no opportunity of rising beyond the high-school course? Who of you would want to lose his ambition and serve an industry on a given annual sum for which they assume the entire responsibility in their hospitals and care for the people of that industry? That is a check strap to all future progress. So that seems to be the simple answer, "There ain't no such animal as an industrial hospital." There "ain't no such animal" as an industrial surgeon. It belongs to the best of the profession to guide and train those who are coming on.

THE INDUSTRIAL DISPENSARY

By F. L. RECTOR, M.D., New York
Secretary, Conference Board of Physicians in Industry

THE industrial dispensary need not have the equipment or personnel of a hospital unless it is remotely situated. The average industrial plant is in or near a community with hospital facilities. The care of minor injuries is all that should be attempted in the routine work of such a dispensary, major work being sent to the larger and better equipped general hospital. In those cases where the industry is remotely situated it will be necessary to provide more ample hospital facilities; but in these cases the general hospital becomes more of a community institution for the workers and their families in cases of injury or severe illness, while the smaller

and more convenient dispensaries for treatment of minor cases are placed in the plant itself.

Dr. Clark of the Norton Company believes, and others agree, that it is necessary from the standpoint of economy and production that no employee should be ordinarily over 15 minutes from a dressing station. In a scattered organization this need can be met by having branch dispensaries in charge of nurses placed at strategic points throughout the work for the first care of injured workers, the physician being on call at the main dispensary and in addition having regular office hours at each branch dispensary. By this means a maximum service can be supplied to workers.

Just a word about records in the industrial dispensary. A fairly representative experience in the inspection of industrial dispensaries has shown that those who keep adequate and intelligent records are in the minority. I have found record forms varying from a blank 3 by 5 library card to a form 10 by 12 inches in size, both sides of which were filled with information about the worker. Many industrial dispensaries religiously collect records and just as religiously file them away without any attempt at analysis.

The proper use of such records can be of great assistance to the production department, as many times the information that they contain will bring to light causes of retarded production that would otherwise escape recognition. Such records often indicate the health standing of the home and community and will enable the plant physican to be of material assistance to the work of the public health authorities.

The physical examination of industrial workers is made of greater value by a proper record system. One important point is frequently overlooked in this work. Some physicians insist upon a very detailed record of the examination of every person, thereby consuming valuable time without an adequate return to the employer or employee. In this connection this fact should be kept in mind: there is a big difference in the physical examination of the industrial worker and the hospital patient. In the case of the worker we are dealing with an individual who is well or thinks he is well, and who is being examined for a specific purpose, namely, his ability to perform certain kinds of work. Only those conditions which have a bearing upon his employment are of immediate interest to the examiner. In the other case the hospital patient is sick or thinks he is sick and the examiner is justified in going to extreme lengths if necessary in order to find out the true condition of the patient.

The earnest effort of most of the physicians in industry to utilize the services of all who apply, even though some may be defective, is doing much to break down the opposition to physical examinations that has existed on the part of some workers and particularly the labor organizations. The Conference Board of Physicians in Industry has formulated the principle that, provided there are positions to be filled, employment should be denied no one unless, when employed, he becomes a danger to himself, to others, or to property.

As to staff organization in the industrial dispensary, I found in a recent survey of over 200 plants, that in 101 establishments with one or more full-time physicians, there was an average of one physician to each 3,083 workers. Please keep in mind that the figures just quoted are *averages* only. In any given case the staff organization required will depend not so much upon the number of employees to be served as it will upon the character of the industry and the different functions delegated to the medical department.

Another important consideration of the work of the physician in industry, and of the value of the industrial dispensary to the workers, is that of the administrative responsibility of the head of the medical department. In visiting nearly 100 industrial plants in New England last year it was found that in only 39 was the medical department under the direct supervision of an executive of the rank of works manager or above; while in 44 other plants the responsibility was to the employment manager, industrial relations superintendent, or other subordinate official.

In the survey of 207 plants just referred to, which covered more generally the larger industrial sections of the country, the same conditions were found to exist. In 108 plants the works manager or a higher executive supervised the medical work, while in 95 plants this work was under the person in charge of industrial relations, safety, employment or compensation, office manager, or other subordinate. Obviously the work of a department of the importance of the dispensary should be accorded the standing of other major divisions of an industrial establishment.

Discussion on Industrial Hospitals and Dispensaries

J. B. Lowman, M.D., Johstown, Pennsylvania: It has been my privilege to be connected with, I think, perhaps the best industrial hospital that was ever built in the United States, forty years ago. At that time, as you know, the corporations did not realize what benefit they would derive from taking care of their own sick and wounded. Through my father, the Cambria Steel Company was induced to build a small hospital for the care of the sick and wounded. They appropriated the sum of ten thousand dollars for this hospital and founded ten beds. It was very hard at first to get any patients into this hospital establishment. But finally, after a certain length of time, the usefulness of it was discovered by the corporation and that hospital has been increased from that time on, until last year they built a new hospital costing about eight hundred thousand dollars. That simply meant the advisability of taking care of the sick and wounded not only from the humanitarian standpoint but also from the financial standpoint.

William O'Neill Sherman, M.D., Chief Surgeon, Carnegie Steel Company, Pittsburgh: During the war, fifty thousand two hundred and eighty soldiers were killed. During that same period, there were one hundred and twenty-five thousand accidental deaths in this country. Thirty-five thousand were killed in industries. Seventy-one thousand were killed outside of industries. Of this number twenty-five thousand children under the age of twelve were killed. There were two million injured, the disability lasting one month or more. And basing our statistics on the monthly disabilities, I would say there are twelve or fifteen million minor injuries of a disability of less than one month. In Pennsylvania in 5 years there were fourteen thousand two hundred and forty-two fatalities, three hundred and twenty-seven thousand serious and six hundred and fifty-three thousand minor injuries, making a total of approximately one million accidents in the State of Pennsylvania within 5 years, or seven hundred each working day. There were fifty-one thousand accidental and violent deaths in Allegheny County between the years of 1903 and 1920, inclusive. The compensation costs in this State, for the killed and injured in these 4 years, amounted to forty-eight and a quarter million dollars. The statistics of the New York Compensation Commission show that 33 per cent of the cases coming up for compensation adjustment require further reconstructive surgery. In other words, the general surgeon's or the general practitioner's work has to be reviewed and referred to an orthopedist or some one else who is doing his reconstructive work. That is an indictment of the character of work that has been done by the general practitioner. A speaker of the State Compensation Commission some few years ago referred to the fact that in approximately 35 per cent of the cases of application for compensation there was evidence of infection. That is another indictment against our general surgeons and general practitioners.

While some are still crying: "Why standardize every hospital"? we would say, "The American College of Surgeons should standardize the equipment and should standardize the methods of treatment."

Some of our failures have been due to neglect in therapeutics. We have absolutely neglected electro-, mechano-physical, and hydro-therapeutics. I have it from very good authority, a gentleman who has visited every hospital in the country, that there are very few of the hospitals which are equipped along these lines. And as the result, we are driving the people into osteopathy and to the chiropractor. We are responsible for it.

The American College of Surgeons should standardize industrial hospitals

There is no question, gentlemen, that the American College of Surgeons is the institution through which a higher and more scientific work can and should be introduced into the industries of this country, and that embraces necessarily the railroads and all of the great industries of our land.

I do not mean that they should have a policy of "You must do so and so," but a policy of this kind, that "Upon investigation, we believe that this or that method has brought about the best results." And in this way the industries having hospitals would whenever possible introduce standard methods.

General Discussion

Mr. Daniel D. Test, Superintendent Pennsylvania Hospital, Philadelphia: I want to congratulate the College of Surgeons on its program of standardization, and the splendid progress it has made. Hospital standardization means the standardizing of the personnel as well as hospital equipment and practice. This means managers, doctors, and executives, and all must have a share in the work. Until we seek to standardize ourselves, our efforts to standardize our hospitals will be feeble.

So long as managers fail to recognize that sound hospital management rests upon fundamental principles which have been established by experience; so long as doctors insist on policies that their colleagues do not want or approve; so long as superintendents try to make rules for everything, and then think that their rules are as sacred as the laws of the Medes and Persians, just so long will hospital standardization be impossible and hospital work be inefficient.

The old idea of each group being suspicious of, and antagonistic to, the others must give way to a co-operative partnership which will co-ordinate all the efforts which the hospital makes. If this result is attained, the doctors and superintendents through their organizations must talk and work for sane standardization, and we must seek to impress upon managers the necessity for their joining heartily in the work, with a view to standardizing themselves as well as their subordinates—the doctors and the superintendents.

The progress which the College has made since its meeting in Chicago 4 years ago should give us fresh inspiration for further effort. Two days were given to standardization at that time. When I think of the first day and a half of that meeting I am reminded of how I was impressed with the great need for standardization among the physicians present. During this time one doctor after another spoke of the importance of standardization, but before closing his remarks every one said in effect that nothing must prevent the doctor from having everything he wants and just when he wants it. I was wondering how standardization was going to have a chance when on the afternoon of the second day a doctor began his remarks by saying: "It is about time we were turning from the consideration of what we want, to the consideration of what we ought to have, with due regard for the other departments of the hospital." This entirely changed the key-note of the meeting, and seems to have set a standard for us all.

I do not speak of this in a critical spirit; but merely to show the progress that has been made. The attitude at the time was perfectly natural. None of us had thought the matter through. We were still living under the old dispensation of hospital work. The new dispensation of co-operation has dawned, and the College of Surgeons has sounded the first call.

Mr. John Smith, Superintendent, Hahnemann Hospital, Philadelphia: In the 3 or 4 years that the American College of Surgeons' standard of diagnosis and records has been in progress, we can see a wonderful improvement in the treatment that the patient gets, the treatment he gets immediately after admission, the preliminary history, and the laboratory privileges, and throughout this whole program we have become more careful, and the patients themselves have received a wonderful benefit from it.

George O'Hanlon, M.D., Superintendent, Bellevue and Allied Hospitals, New York: The program has been most interesting and most helpful, not only to those that have already met the standard during the past 3 or 4 years but to those who are still "without the faith." I am very sure that after this meeting the trustees, the attending staff, and everybody connected with the hospital will make it their individual and combined effort to meet the requirements. They are so simple although in some cases expensive. They can without any difficulty be met.

I happen to be connected with five hospitals, all of them teaching institutions, with one exception. When the standardization of hospitals was introduced, we met the requirements. They are City institutions, maintained at the expense of the City of New York.

In passing, I might just tell you—those who are unacquainted with hospital organization in New York—that the general hospitals of Manhattan are under a board of trustees. The public hospitals of Brooklyn, Staten Island, and Blackwells Island are under the commissioner of public welfare. The commissioner of public welfare took the lead, 2 or 3 years ago, and issued a general order applying to each and every hospital of the Department, directing the staffs to comply with the minimum standard.

For several years it has been our practice to have not only the regular staff meetings and attendant staff meeting, but the administrative staff meet at least once each week; the superintendents, assistant superintendents, superintendents of nurses, purchasing agents, doc-

tors, and all the people who were recognized as heads of departments are called together each Saturday morning. The general affairs of the institution or of the department are taken up and discussed, so that each person knows the difficulties that we have to contend with, whether it is difficulties with the attending staff, difficulties in the operating room, difficulties in getting money from the City Fathers, changes in the personnel, changes in the pay-roll, and even the question of infection in the wards. The superintendents and pathologists of each of our hospitals attend all meetings of the board and present a report of the work that has been done at each hospital and the sources from which these reports come, so that it is apparent who makes use of the laboratory and who does not, and the amount of increased interest and care shown. A few weeks ago at one of the hospitals complaint was made that the laboratory service was not satisfactory and the pathologist was not present to report. So the next meeting we asked him to attend and give in detail the amount of work he was doing and the sources from which those requests came. During the preceding month, the hospital, with perhaps four hundred admissions, and a very active service, made requests for two blood counts. I think six autopsies had been performed. They asked why he did not do more. He said no one asked for more; that he had on one or two occasions gone into the wards to learn something about the cases, and it was made very apparent to him that he was not welcome; so that he had profited by that experience and lost his interest. And as the result of that conference, the staff are making much more use of the laboratory.

GENERAL SUMMARY OF HOSPITAL STANDARDIZATION AS INAUGURATED BY THE AMERICAN COLLEGE OF SURGEONS

By MALCOLM T. MacEACHERN, M.D., C.M., Vancouver
Superintendent, Vancouver General Hospital

SUMMARIZING hospital standardization, as inaugurated by the American College of Surgeons: You have come here with set opinions, you have gained new opinions, your old opinions have been intensified by this wonderful meeting today. But how are we to think of this hospital standardization meeting? What is your psychological reaction? You have been impressed with the fact that this movement pleases all.

Now, one or two thoughts: First of all, because of the better working out of the cases in the hospital, because of better diagnoses, because of more intelligently applied treatment, because of the staff review conference work, what are your hospitals showing statistically? If we were prepared to present complete statistics today, they would absolutely run like this: lower death rate; reduced number of operations; fewer postoperative infections and complications; and lastly a lessened patient's days' stay in the hospital. We have some statistics already showing this conclusively, which may be mentioned at the round table this afternoon.

The second thought: This movement has created a deep sense of responsibility in our so-called hospital groups in the care of the sick, whether in the hospital or outside. First of all, the administrative side of the hospital has been affected as you have been told today. The staff of the hospital has become more conscientious to its duty. Second, the medical men have been impressed by the movement and are trying to mold their ways to produce better and more scientific results. Thirdly, the boards of trustees are realizing their responsibility. They are realizing, indeed, that they must have two reports: first, a financial report; and second, this report, what I could call the physical report of the hospital, showing the physical assets and liabilities. And the assets are: patients discharged well and improved. The liabilities are: deaths, unimproved cases, infections, and complications. And from these they make their balance sheet.

The next thought: what are the people thinking about this? Before they go in for treatment the people are now asking what hospitals are meeting this required standard.

This program that you have heard today surely has impressed you with the fact that it has carried a message of better service in the hospitals of both countries and hundreds and hundreds of thousands of patients, now and later, must surely benefit by it.

Lastly, how does it affect the nation? It is one of our great economic questions, because it means that by hospital standardization there are fewer deaths, there is less cost to the hospital in the care of the patient from fewer complications and infections, and finally there is a shortened days' stay in the hospital, which means, as the industrial representatives have told you, putting the patient back to producing capacity sooner.

AFTERNOON SESSION—ROUND TABLE CONFERENCE

HOW HOSPITAL STANDARDIZATION CAN IMPROVE THE PROFESSIONAL WORK AND THE SERVICE TO THE PATIENT IN THE HOSPITAL

CONDUCTED BY MALCOLM T. MACEACHERN, M.D., C.M., VANCOUVER
Superintendent, Vancouver General Hospital

DR. M. T. MACEACHERN: Before starting the Round Table, I want to mention seven points which I think are stimulating at this time in order that we may give better service in the hospital to the patient, and it may in a way summarize the work.

First, giving to the patient upon admission a good reception so as to put the patient in a comfortable mental attitude toward the hospital and the staff, so that the patient will react more favorably to treatment.

Second, prompt attention at all times to the patients' needs, whether large or small.

Third, competent examination of the patient, with a carefull record of the same; a careful record of everything concerning the patient while in the hospital.

Fourth, availability and utilization of all the diagnostic and therapeutic facilities necessary in making a good diagnosis and carrying out effectually applied treatment. Get the two points—first, all the facilities for a good diagnosis, and second, all of the facilities for effectually applied treatment.

Fifth, consultations between your staff; consultations between the staff and the administration; consultations both scientific and administrative.

Sixth, careful analysis of the work that you heard so splendidly put to you this morning in the staff conference, and, Seventh, intelligent monthly reports to the board of trustees.

Now, this means better diagnosis of your patient, better application of the treatment, and return of the patient to producing capacity as quickly as possible in the most efficient and most comfortable manner. That is what your patient expects of you as hospital administrators and as surgeons and physicians. That is what the public, as the financial support of your hospital, expects. Just as in a factory, putting out a certain product, so our product here is health, which must be of the highest standard. Now, these services which concern us chiefly today are scientific services of the hospital, for which we can set no limit.

SECTION A—STAFF ORGANIZATION

1. *Many hospitals find difficulty in formulating staff by-laws, rules, and regulations for the guidance of the professional work therein. How can the College give them greater assistance? Can they secure a set of standard by-laws, rules, and regulations setting forth the principles involved which shall guide them in drafting their own?*

DR. FREDERICK W. SLOBE, Chicago: There have been many changes in the general policy and system of the staff rules and regulations during the past 5 years. Originally, the constitution of hospitals embodied general principles of organization chiefly, and contained practically no details relative to the clinical management of the hospital. During the last 5 years, however, as a result of the great emphasis placed upon staff meetings and staff organization, case records, and laboratory facilities, in the standardization campaign, there has been great emphasis placed upon certain rules which would carry into effect the principles of the minimum standard.

Of course, there is no one standard set of staff rules and regulations which can be applied to all hospitals. Naturally, a hospital of fifty beds in a small community cannot use the same constitution and by-laws which would be applicable to a large hospital in a metropolitan center. Therefore, the College advises certain broad principles only, leaving the detailed application of these principles to the various individual hospitals themselves. There are certain general rules, however, which have been incorporated in practically all of the rules and regulations. Many of these are so elementary that they may seem entirely unnecessary to some of you who have been associated with larger hospitals in the larger centers. I can assure you, however, that these same rules are almost revolutionary in a great many hospitals scattered over the country. I will mention just a few of these rules which have been adopted and incorporated into the by-laws of various hospitals.

1. That the staff conference include a careful analysis of the results obtained in the hospital during each preceding month.

2. That regular attendance at staff meetings be insisted upon, attendance being expected of all physicians who have had patients in the hospital during the preceding month.

3. That the physicians afforded the privileges of the hospital abide by its regulations and that the practice of fee-division be absolutely prohibited.

4. That the case records be written within 36 hours after admission.

5. That a history, physical examination record, and pre-operative diagnosis be recorded before operation (except in emergencies).

6. That no case record be filed until it is complete.

7. That every specimen removed at operation be sent to the pathological laboratory for a report.

8. That a system of laboratory charges be worked out which will allow every patient to receive adequate laboratory service.

These rules are general and neither impede the initiative of any of the staff members nor hamper individual judgment. The announcement of a definite policy of this kind by a hospital is an expression of its endeavor to live up to its responsibility to the community.

At the College headquarters we have various samples of staff rules and regulations adopted by hospitals in their endeavor to meet the standard. We will gladly send out these samples to any one interested.

2. *Many hospitals require the attending doctors to sign a pledge or card, the latter often being known as the "Physicians' Registration Card." Has this been found beneficial? What is the best form to use?*

DR. FREDERICK W. SLOBE, Chicago: In order that the physicians may clearly understand a hospital's policy, it has become quite customary for hospitals to obtain the physicians' signatures to the constitution and by-laws. In other instances individual declarations are drawn up, stipulating an agreement to abide by the rules and regulations of the hospital and a pledge against the practice of fee-division. In still other instances, an individual fee-splitting pledge is the only form used. Cards are sometimes used to serve the same purpose.

This procedure on the part of the hospital should not be viewed as derogatory to its staff members. Instead, it is a means of demonstrating to the community the hospital's endeavor to uphold a high standard of medical ethics and practice.

The College has some of the forms which are used by the various hospitals in this connection and will gladly send them to any one on request.

DR. E. R. SECORD, Brantford, Ontario: Just to provoke a little discussion, I will say that we have no cards, no pledges, and as far as I am personally concerned, I am of the belief that he who desires to split fees or otherwise act in a way contrary to the standards that we believe to be proper will not be bound in any way by any mere signature attached to constitution and by-laws, cards, pledges or anything else of the kind.

A MEMBER: The signature to the by-laws and rules and regulations, as mentioned by Dr. Slobe, will have a moral effect on the professional bodies of the hospital.

3. *In certain instances the attending doctors of hospitals have been found lacking in clinical interest. What can be done to stimulate more interest in such cases?*

DR. H. J. MOSS, Brooklyn: The question that we are discussing now seems almost unnecessary. After reviewing the work of standardization of the American College of Surgeons this morning, whereby each surgeon is expected to do the right thing by the patient in the matter of keeping records, it seems to me that this answer takes care of itself.

In the first place, your staff should be appointed only for the period of a year and at the end of the year re-appointments should be made upon the work that each and every member of the staff did during the year. If a record or inventory is kept during each month of the year, it becomes a very easy matter at the end of the year to take a gross inventory of the twelve months and find out what the particular surgeon has done during that given year. You have then, at the end of the year, your whole record of the total of infections, the number of deaths, of that particular surgeon.

In other words you have an absolute inventory of everything that the man has done during the year. Then if he has fallen short of the requirements, that particular man should not be re-appointed.

If you adopt that rule, I think you will not have to be concerned about the interest that each individual doctor shall take in his individual work.

A MEMBER: I have found in hospitals the best clinical stimulus is the staff conference. In the

modern hospital the material that is discussed at staff meetings is a great stimulus.

4. *How often should the staff conference be held and what is the best form for it to take, a luncheon, a dinner or an evening meeting? What should constitute the agenda for such a meeting?*

DR. FRANK J. JENNINGS, Brooklyn: As to the frequency of staff conferences, we feel that that is largely a local matter. Hospitals and staffs vary. In the average general hospital which has on its staff a good many general practitioners, we feel that a meeting held once a month is to be preferred, and that it should be a convenient meeting, the later in the evening the better, subject to certain limitations. I do not mean to hold it at midnight, but at 9 or 9:30, so that the man in general practice who has evening office hours has a chance to take care of his office or to make a call or two if he has to make it, and get to the staff conference.

In a small, closely controlled staff, the weekly meeting is a splendid meeting; as, for example, at the Woman's Hospital at New York under the direction of Dr. George Gray Ward. When a hospital is starting staff conferences and perhaps has friction or factional feeling to eradicate, a lunch or dinner may be the means of expediting or facilitating the starting of the conference.

Now, as to the "agenda." For the successful formation of the staff conference, you must have a ritual if you are going to succeed. Doctors do not vary much in temperament or character all over the country, and they have not quite reached the point of beginning a staff conference. So the first thing that we believe is practicable is to form a staff conference committee. This is composed of three members, representing the different services in the hospital. It is very essential to have as chairman of that committee a level-headed man who is a good presiding officer.

In the development of conferences, the first thing that is a matter of attack is the record. You have heard described this morning and also this afternoon by Dr. Slobe what a good record should contain. There is no necessity for my going into that, but you will find that through staff conferences your records will steadily improve. At our last staff conference held at St. Catherine's, I think the strongest impression any one would take away was the high quality and excellence of our records.

Mortality we believe is properly a subject for review. The records of those who have died are looked over and those which may point a lesson in any way are selected. The man who is responsible for the case, abstracts the record and reports it. Now, that has a didactic value which to me is beyond criticism. At the last conference a death from incision and drainage of an abscess of the thigh, secondary to osteomyelitis of the femur, was reported. Just to show you the value of that particular report: the patient had taken a general anæsthetic and had gone through a forty-minute operation when her actual surgical capacity should have reminded the surgeon to keep her in bed and to make a small incision only. The lesson conveyed to them was that they should be on the lookout to see that they did not go beyond the limit of the patient's surgical endurance. And you can multiply that *ad infinitum* with consequent good, first of all to your staff, and, of course, always to the patient.

Morbidity, we believe, is a profitable and proper subject for review. Reviews and analyses offer a field that is limitless.

In closing, I may say that the staff conference committee has no rose-strewn path to walk on. They are the subject of criticism almost always, allegations being made that certain men are being favored or that certain men through the conference committee are excluded from conference for one reason or other. We have difficulties with the coterie which says that the whole thing is illegal; so that what we have accomplished in holding staff conferences has been done at the expenditure of a good deal of energy and by overcoming a great deal of criticism.

A MEMBER: A large number of hospitals review three things: the deaths, the unimproved cases, the infections, and the complications, each month.

DR. R. L. DICKINSON, New York: I would like to speak of the Woman's Hospital. Dr. Ward runs one of the best staff conferences I have seen. He begins with a brief presentation by the pathologist of interesting cases. Then he takes up the casualties, man by man. Each man at the head of a service is asked to report for his service, any deaths, any infections, any complications, and any errors in diagnosis. Then the follow-up is taken up, not each week, but once a month. Some interesting cases are taken up and the thing is a very live, keen, active meeting covering one hour.

Another of our excellent reviews is on a different basis. I refer now to Dr. Eugene Pool's conference in the New York hospital. It takes one hour, Friday, at 12, his whole staff being present. His conference is a little review of the staff itself. They have their pathology at a

separate time. They go over their X-ray work after lunch. They take up the errors of diagnosis, the follow-up work, and a general review once a month. They break up the meetings and that is very much better than running 3 hours on one afternoon or evening when everybody is tired out.

The great problem, I take it, is with hospitals open to many men. I recall one instance in a certain hospital—a doctor did not appear at a meeting, following the death of one of his patients. Before the following meeting he was notified, with a statement signed by the superintendent, that if he did not care enough for the service to obey the rules and come and report his casualty, his resignation would be welcomed.

5. *What is the best way to stimulate more consultations between members of the staff in hospitals?*

Dr. John Smith, Philadelphia: Based on nearly 3 years experience with staff conferences, I would say that the answer to this question, how to stimulate more consultations between members of the staff in hospitals, is the clinical conference. What is needed is a feeling of kindliness and co-operation between the various members of the staff and various groups of specialists and there is only one way of doing that and that is through the clinical staff conference. I mean the general conferences as well as the group conference. The group conferences are important, but in order to get consultation you have to get a feeling of good-will and friendliness between the various groups, and a general staff conference is the only way to accomplish it.

In one hospital with which I was connected, up to 15 months before we started the staff conferences, consultations were really rare. We started the staff conferences and before long the men commenced to ask other men to come in and see their cases, and soon we had splendid statistics on consultations, and I believe that is really the only way that it can be done.

SECTION B—MEDICAL RECORDS

1. *Should not every medical man be responsible for seeing that a complete history is provided for each one of his cases, whether public or private?*

Dr. M. T. MacEachern: I think the spirit of the question means that the physician either writes the record himself or sees that somebody writes it, and that it is of good quality and complete. First of all, let us have a show of hands. How many of you think that a doctor should be responsible for a complete history in the light that I have explained? (Vote taken—large majority in affirmative.)

Dr. S. G. Davidson, Superintendent, Rockford Hospital, Rockford, Illinois: On this subject of records in the hospital, should the doctor be responsible for the records? Of what value is the record to anyone except the doctor, primarily? So why should he not be responsible for it? Every man knows that the value of the record to him and his patient lies in the fact that he can go back to those records 1, 2, and 5 years, and study his cases and give his patients better service next year, and better service this year than last. If they are not responsible, who is?

Mr. C. A. Lindblad, Superintendent, Buffalo Homeopathic Hospital, Buffalo, New York: I just want to give you a little experience on this subject. Our institution is an open hospital, but only reputable physicians, physicians approved by a committee, are given hospital privileges. I think that the great difficulty is that the average hospital superintendent is more or less afraid to ask the physicians to do a little work. Three months ago, shortly after I assumed charge of this institution, I wrote a personal letter to each man doing work in our hospital—and by the way, there are some seventy-five or eighty taking care of the private work—and asked each of the men sending a patient to the hospital to write his own histories or see that they were written. As soon as the patient is admitted to the hospital, the hospital statistician in charge of the record room prepares the history blank and mails it to the physician. This letter simply states that we would like to have him complete this preliminary personal history and the working diagnosis and return it promptly in the enclosed stamped envelope. This history can be prepared from his personal knowledge, by his office or clinical assistant, nurse in his office, or he can do it himself. This attempt was simply a try-out to see how it would work, and since we started this three months ago, we are getting 95 per cent of those histories returned to us in fairly good condition.

2. *What is the best way to secure operating-room records and what should they consist of mainly?*

Dr. Simon Tannenbaum, Superintendent, Jewish Hospital, Philadelphia: This question naturally resolves itself into two headings, namely the records that are necessary or essential, and the method of obtaining those records.

If I were asked to say briefly what those records should consist of, I would say that the record should consist of everything relating to the

patient from the time he is taken from his bed for the operation to the time he is returned to his bed from the operation.

These records consist of three parts: first, what is known as the record of the operating room; second, the record of the anæsthesia; and third, the record of the operation.

Now, first, the record of the operating room is a big book which is usually kept in the operating room and consists of brief entries of the patient's name; his location in the hospital; the operation; the name of the surgeon, the name of the assistant and interne and also the name of the anæsthetist.

The record of the anæsthesia should consist of the record taken immediately beginning with the time the patient is removed from his bed, and should contain, first of all, the record of the pre-anæsthetic period—the pulse, respiration, temperature, blood pressure, and, as well, his general condition and the condition of his heart and lungs. Next, the stage of the anæsthesia; the kind of anæsthetic used; quantity used; the condition of the patient during the anæsthesia, giving fifteen-minute record of the pulse and respiration; then the conclusion of the anæsthesia, stating what the condition of the patient is, including his pulse, respiration, and temperature.

The next is the record of the operation itself. Now, it may be a record on a sheet by itself or it may be apart of the general history. That is a matter of choice. The record should contain the pre-operative diagnosis. That is one of the most important parts, perhaps the most important part, of the record. It should then contain a description of the operation, describing step by step, giving the source of pathology, the organs explored, stating whether they were normal or abnormal; the closure, what ligatures were used, and so on; and a most important record, not to be forgotten, is whether drainage is left in the patient.

Now, we come to the method of reporting the operation. That is a matter of choice. Some operators can dictate the operation during the operation itself. Some of our very best surgeons do. Others leave it until the operation is over. It should, however, be dictated immediately after operation, giving in detail, as I said before, every stage of the operation. It is dictated sometimes to the anæsthetist. It may be dictated to a stenographer who is there for that purpose. It may be dictated into a dictaphone, which does not require anybody's time and can be taken off at any time.

The question whether the report of the operation should be dictated by the surgeon himself or whether it should be dictated by the interne is one which is still open. The educational value of having the interne dictate the operation is apparent. If the interne dictates it and it is then read by the surgeon, the interne will certainly be benefited a great deal by it.

Accurate records will very strongly show the character of the surgical work performed in any hospital. It will stare the surgeon right in the face and will show him how often he has been mistaken in his diagnosis and how often he has been right. And that is the kind of record I believe should be found in every hospital.

Dr. M. T. MacEachern: I think Mr. Tannenbaum has covered the subject very fully. On the method of reporting the operation, he gives us, first, the stenographer; next, the dictaphone; and last, the surgeon writing it. The most satisfactory seems to be dictation to a good stenographer.

3. *What is the best procedure to keep accurate records of all postoperative infections?*

Mr. James U. Norris, Superintendent, Woman's Hospital, New York: At the Woman's Hospital, we have a record form of a distinctive color and on it is recorded every dressing from the time of operation, name of Doctor removing drain, number of sutures, wound healing, the promptness of union, condition of wound on discharge, list of dressings, and character of dressing. That is part of every history.

4. *Who should be responsible for overseeing of the medical records as to completeness and quality?*

Dr. F. L. Adair, Chief of Staff, Swedish Hospital, Minneapolis, Minnesota: A question of responsibility is involved in the answer to this question. And it seems to me that we should recognize responsibility of two kinds: First, the collective responsibility of the hospital to the community as a whole. This involves the medical personnel, the nursing personnel, and every individual engaged in carrying out the proper functions of a hospital. The individual responsibility of the physician to the patient cannot be taken over by the hospital, nor can the collective responsibility of the institution be taken over by the physician. It may be assumed largely that both the institution and the physician are responsible for the completeness and quality of these records. The keeping and preserving the records is easily the function of the administrator of the hospital, and can quite readily be taken care of by somebody. It is merely checking of the different sheets, to see that they are present in the record before the record is filed away. Administration is also re-

sponsible for the enforcement of this, because it is responsible to the public for the maintenance of these records as one of its functions and obligations to the community.

The accuracy of the records cannot possibly be checked by the administrator nor by the historian, or record clerk, whatever she may be called. That must be up to the individual medical men. No one else can be responsible for the accuracy of the records. And it is better probably not to have any records than to have inaccurate records. Of course, a certain amount of inaccuracies will creep in, but on the whole, if records cannot be depended upon for accuracy, they are worse than useless.

The attending man or the visiting man who is responsible for the care of the individual patient must either supply the record from direct contact and direct history and examination of the patient or he must do it by proxy through a member of the house staff. Either one of these might work out differently in different institutions. In the last analysis, the enforcement of the accuracy of the record is not up to the hospital administrator but to the staff, because medical men are the only ones competent to pass upon the fundamental accuracy of these records. This is done, as has been pointed out, through these monthly conferences, where the records are subjected to the scrutiny of medical men.

There is another point and that is the duplication of records where the physician keeps in his office complete records of the case, as any up-to-date medical man should, and when the patient goes to the hospital, a record of the case should remain in the hospital. This involves a certain duplication of effort and the cost of it comes back on the physician or the community, as the case may be. It seems to me that the logical ultimate solution of this question is through a closer association of physicians with hospitals, so that the institution and the physician's office ultimately become consolidated, so that, instead of duplicating records there is finally only one record and the work of the medical man becomes identified with the institution. It seems to me that that is at least one logical conclusion of this problem.

Dr. W. A. Hausman, Jr., Allentown, Pennsylvania: I think it would be easier to bring about the writing of records if a rule were made that all cases must have their records complete before the patient can be operated upon. The provisional diagnosis must be made at the time of the examination of the patient and those records must be completed before the patient is operated upon.

As to the question which is up at the present time, at the Sacred Heart Hospital we have made it a custom for the chiefs of the departments to O.K. records at the completion of the case and each one of the records is gone over to see whether the record is there in its entirety. We pay no attention to small errors or differences in diagnosis or things of that kind at the time, the aim being to see whether that record is complete or not. The chief of the department goes over the same and passes it if it is correctly filled out. If not, it is passed back and is not filed and is placed among the incomplete records until such time as it is corrected by the surgeon in charge.

Dr. G. E. Follansbee, Cleveland, Ohio: I cannot agree with what the speaker has said about the responsibility for the record. Theoretically he is right but practically I believe he is wrong. A man's conscience in a great majority of cases in the hospital staff is not a sufficient club to make him give you a complete, accurate, and truthful record. He may make his record complete, but I will question a great many of the records in a hospital as to their truthfulness unless those records are carefully gone over and minutely inspected with a suspicious eye by a competent record keeper or a man familiar with records.

This matter has come to my attention before and I have been somewhat interested in looking over the records in hospitals to see how well those records were kept, and I am sorry to say that in some hospitals, with apparently satisfactory records, careful investigation revealed very untruthful records. I believe that the responsibility of a correct record belongs in the hospital and that there should be some one in the hospital, preferably connected with the staff and interested in the matter of records, a sub-officer of records, whose duty it shall be to go over those records with a fine-toothed comb. If we do that and then untruthful or unsatisfactory records are brought up, we can get records that are of some value. But of what value, I would like to ask you, is an untruthful record in any hospital. You are better off without a record than to have an untruthful record.

Dr. Edward A. Weiss, Pittsburgh, Pennsylvania: We have found that the most satisfactory method of proving the record as to correctness and completeness is to have a committee of three from the staff. Each man takes 2 hours a week and goes over the records in the record room and approves them if correct and then they are filed. If incorrect or deficient in any respect, a note is made on that record and the individual member of the staff to whom the case belongs is

then called to the record room and required to complete it. If a blood count, for example, has not been made, he is required to write on that record why this was omitted, etc. This committee serves for 3 months only and then three other members of the staff are appointed. No member of the committee is permitted to pass on one of his own records. This has worked very satisfactorily with us.

DR. E. A. SOMMER, Portland, Oregon: I believe that the hospital ought to furnish a stenographer to take the record of the operation and place it on the history and then allow the surgeon to O.K. it.

SECTION C—LABORATORIES

1. *What laboratory work should a hospital of 75 to 100 beds provide as a minimum service?*

DR. M. T. MACEACHERN: To expedite matters I have distributed a little pamphlet covering this subject (sent on request).

2. *A hospital wants a routine pathological service in connection with their surgery. How can such a service be financed?*

DR. S. G. DAVIDSON, Superintendent, Rockford Hospital, Rockford, Illinois: How can such a service be financed? That is the main question. We had that up this morning—the cost of the work. It was just brought up that we should have a stenographer in the operating room.

Laboratory work is admittedly one of the most essential in our hospital service. And how can it be financed? Just how much laboratory work do the attending men want? What laboratory service should a hospital of 75 to 100 beds provide as a minimum standard? Why, you want the best, do you not? You want everything you can have, don't you? And you want the tests made by the most competent laboratory people.

To answer the question, you have to group your hospitals into two groups: the hospital in the small community and the small hospital in the large community where there are a number of other larger hospitals.

In the small community, if the attending men in the hospitals or in that community will make proper use of the laboratory it is going to multiply its service over and over again every single month and there can be no question about financing it. Unfortunately, it becomes necessary for every hospital superintendent, when he has established a first-class laboratory, to begin to educate his attending men to make use of that laboratory. I just had the pleasure this year of installing a laboratory in a hospital of one hundred beds in a community of seventy thousand people with two other hospitals, all small. I think that is one of the crying disgraces—three small hospitals in a community of seventy thousand, with all their overhead, with all their mismanagement, when any one hospital with the same number of beds could take care of all those patients and do it so much better.

We installed a laboratory costing one thousand, five hundred and eighty-eight dollars, equipment enough to take care of a hospital of three hundred beds or more, and we employed an excellent pathologist. We are paying him thirty-five hundred dollars a year and 50 per cent of the net profits. Some of the medical profession felt that a pathologist was not worth more than from twenty-three hundred to five thousand dollars. At those figures we cannot expect men to take up that work. But when the medical men begin to wake up to the fact that that is one of the most important services we have, they will begin to pay pathologists seven, eight, or nine thousand dollars a year. And then you are going to have good work done. We feel that our man would be able to earn at least six thousand dollars a year. How do we finance it? We take the cost of the operation of that laboratory, pro-rate it over our bed charges, and add 50 cents a day. This enables us to give all the laboratory service that the attending men ask for, routine analysis and so forth, anything that he wants is done and as much of it as is wanted. They do not have to ask the patient or tell him it is going to cost more. We figure on a basis of 30 per cent, which means 50 per cent for your smaller hospitals of 40 or 50 beds.

3. *How many hospitals are routinely putting through all the material removed in the operating room and thus checking up diagnoses?*

DR. M. T. MACEACHERN: This calls for a show of hands. (Vote taken.) I am glad there are so many.

Right here I want to tell you, you who are building new hospitals, do not forget to put your laboratory next to your operating room and your operating room where your pathologist is at your surgeon's elbow. We have proved its value.

4. *How can the pathologist arouse more interest in the clinicians and internes along laboratory lines?*

DR. A. K. HAYWOOD, Montreal: There evidently must have been some reason for putting this question on the program and the reason is that the pathologist must arouse more interest

in the clinician and in the interne. If you will show me a hospital that is popular, doing up-to-date work, I will show you a hospital that has a keen pathologist. The pathologist must have a keen interest in the clinician. He must be able to come and decide with the clinician, not in a spirit of criticism but as a consultant, in a spirit of helpfulness, and if you will apply that, you will find that in practically every obscure case your pathologist can be of inestimable value to the clinician. He doesn't examine merely for his own interest or for any financial gain. He examines more and more in his laboratory in order that he may be able to render some service to the patient. He must be confidential, he must be kindly disposed, his criticism should be softened with a certain amount of patience, he must make the interne welcome when he comes into the laboratory. If he is going to arouse interest, he must make them feel welcome at all times to come into his laboratory and chat over obscure or ordinary cases. The pathologist's laboratory is a source of supply for many interesting discussions. It does not matter where the laboratory is situated, if the pathologist is a keen, tactful fellow-being, he will attract the interne and the clinician to his laboratory. In clinical pathological conferences, the pathologist in many cases acts as judge and jury. He can commend and he can criticize, and it is only reasonable, when mistakes in diagnosis have been made and it is necessary for the pathologist to draw the attention of the attending men to them, that he should do that in a manner that is not offensive.

All diagnoses should be made on every case in black and white and put down on the history and the pathologist should insist that the history gets to the postmortem room.

A pathologist will very often forget that he is talking to students and to internes. He must be very guarded so as not to talk over their heads. If the clinicians and internes have implicit confidence in the pathologist, if he is a tactful and kindly pathologist, I do not think that he will have very much difficulty in interesting the clinicians or the internes in laboratory methods.

DR. MACEACHERN: Dr. Haywood brought out two points, the sending in of the various diagnoses by the clinicians and internes to the postmortem room, and second, the pathological staff conference. On my way here, I attended for a few minutes one of the conferences referred to, at which the internes and the different members of the surgical service met the pathologist. They meet every Friday morning to discuss the pathology of the week.

A MEMBER: I know a great many pathologists and I know that they differ just about as much as do clinicians. So I believe that the only way to arrive at any conclusion is by hearty co-operation between the pathologist and the clinician. Take any tissue that is removed. We have all had experience. We send it to the laboratory and get a report. Send it to another laboratory and you will get a different report. One of them is wrong. Let us not lose track of this. And let us remember that the laboratory and the clinician must work together.

SECTION D—NURSING

1. *Can a hospital attain the minimum standard with what is considered an incompetent nursing staff?*

DR. CHARLES H. MAYO, Rochester, Minnesota: We are all interested in the care of the sick which has been greatly changed from ancient customs. The modern methods, proved to be the best, are now accepted by the public. It is only a few decades since hospitals, some in truth hotbeds of infection, were looked on as places to die in, a place of refuge especially for the poor. They are now sought by the intelligent sick who desire the best possible care. No one factor has brought about this revolutionary change. The better knowledge concerning disease and its transmission and prevention, of the educated public who now demand more of the physician, has probably been the greatest factor in bringing about the reorganization: the development of public education in hygiene will be the next great factor.

The trained nurse has given nursing the human, or shall we say, the divine touch, and made the hospital desirable for patients with serious ailments regardless of their home advantages. The rich patient who can pay the price, the poor patient who can pay nothing, may secure the highest service in sickness. But how about the larger group of patients in the middle class, who neither rich nor poor, would be glad to preserve their self-respect by paying to the limit of their ability? The key-note of hospital efficiency today or of any other great movement depending on combined effort is organization. So few hospitals pay their expenses that, like educational institutions, unless they are supported from a bequest, they must be assisted by charity or by the city, state, or some religious or similar organization to make up the yearly deficit. Can a hospital give the minimum standard of care without the most efficient help? The answer is "no" as opposed to public service and the support of

standards of efficiency. Yet, if the hospitals have competent physicians, surgeons, internes, superintendents, and trained chiefs of nurses with intelligent and willing undergraduates much can be accomplished to attain the minimum standard in a comparatively short time. The nursing and care of the sick is a matter of education, and ignorance may be overcome. Knowledge is acquired by a compelling force from within, by desire, or from without, by compulsion. No matter how efficient in general the nursing staff is, the hospital will not be safe and truly serve the best interests of the sick without supervision by some one in authority. This cannot be reversed; the most competent nursing staff cannot replace those who are responsible for the direction or the administration of the organization.

What can be done to maintain the efficiency and save the professional life and dignity of our nurses; can we help them to help themselves? They are compelled to study and labor diligently for 3 years after having achieved a high standard of general education. They are overtrained for nurses and undertrained for physicians. It is true that the training is good for them; the greater number marry, and the wide general knowledge they have acquired is, in fact, of more value to them, their children, and the communities in which they live, than are college degrees, as it contributes to better national health and a more practical citizenship. The records of St. Mary's Hospital in Rochester show that of the nurses graduating for the ten years preceding the last three years, 1 per cent are dead, and 54 per cent are married. Of the class of four years ago, 31 per cent are married. If, then, excluding the last three-year graduates, 2 per cent are out of the work, only 43 per cent are left in the service of the previous ten-year period that has taken the nurses three years of hard, continuous study and work to learn, as long in actual time spent as it takes to study medicine and three to four times as long as it takes to acquire a degree as osteopath or chiropractor. It is evident that the foundation requirements are too high for the average demand, and in all fairness must be made a little higher by specialization, and by giving added responsibilities in positions as technical assistants, or the period of training must be shorter in conformity with requirements for ordinary nursing duty in order that a greater number may obtain the benefit of this educational training.

The course of training should be two years with post-graduate study for the third year, which should be optional, and it should be possible to take it at any time desired, so that those who remain in the work may fit themselves for the work in which there is greater opportunity for service and securing personal distinction. Chief nurse in the hospital, chief surgical nurse, nurse in dressing service, anæsthetist, county, city and school nurse, industrial and child welfare nurse, dentist's aid, physician's aid, and laboratory technician, are but a few of the many positions waiting. It is far from my desire to destroy nursing standards; on the contrary, I wish to advance them for those who remain in the profession with a demand for recognition of ability, responsibility, and honor which will then be accorded.

The patient sends for the physician first. The physician secures a nurse if desired, or he sends the patient to the hospital where a nurse in rotation is assigned by the superintendent. The physician or surgeon must assume the responsibility, even though death occurs from an accident in crae.

Any labor union in which the candidate draws pay or receives only board and lodging while in training, as does the bricklayer, plumber, and carpenter, protects the job by limiting the number of apprentices. In professional life there is some danger in over-organization. The nurse, in accepting unionism, must carefully watch the policies of the organization that they be maintained along professional lines with their legislative efforts directed unselfishly to better care of the sick. As a physician, I am proud that legislative acts sponsored by them, with the one exception of that sponsored by medical anæsthetists, have always been in the interest of public health without thought of advantage to the profession. The physicians' services are always at command for charity, which service the nurse cannot give.

In the interests of the sick I strongly advocate a return to the two-year course as a minimum standard of nurses' training and the development of post-graduate work with a special diploma for advance training. In urging this, I wish to call attention to the fact that in the Great War the medical department under the surgeon-general was developed to the highest efficiency by the valuable aid of the leaders of the department of nurses in Washington, and in the service abroad and at home. Most of the leaders in this group were themselves two-year graduates, thoroughly capable and most devoted to their work.

It has been suggested that those who possess a high-school certificate should be graduated in two years from a course in general nursing, and those desiring training in special branches continue or take such training at a later period. In some

progressive cities, such as Minneapolis, the theory of nursing with the fundamental branches is now given as a vocational training course with 6 months of practical work in a convalescent hospital in the public school system.

2. *Should not all undergraduate nursing service, including especially operating-room and maternity technique, be supervised by competent and experienced graduate nurses?*

Miss C. Lillian Clayton, Director of Nurses, Bureau of Hospitals, Department of Health, Philadelphia, Pennsylvania: Answering Dr. MacEachern's question from the standpoint of the general subject of this afternoon's discussion, my answer should be in the affirmative. Undergraduate nurses should have competent and experienced graduate supervision both from the standpoint of improving the professional work in the hospital apart from the patient and because it provides better service to the patient.

To secure adequate graduate nurse supervision is one of the most important steps in efficient hospital administration. Supervision of undergraduate nurses means much more than the words superficially imply. It means the establishing and maintaining of proper professional relationships between the administration and those supervised, with the patients, the medical service, and all departments related to the wards.

To do this successfully requires tact, ability, education, and experience not possessed by the undergraduate. The value of our nursing service is in large part due to this group of workers. The value of the supervisor lies in her understanding of her own work.

Supervision does not mean interference with those supervised. It does mean, however, that the needs of those supervised most be understood and properly met. These needs are met because the supervisor's own previous education and experience have given her the proper background and her personality makes it possible for her to meet the needs of those supervised because of her own knowledge. In this manner she makes the value of the student greater.

First, because she teaches her accurately to understand the work of the individual in relation to the work as a whole.

Second, because her previous education and experience have made it possible for her to solve problems successfully, she commands the respect of the students and as a result of this the student learns to solve problems for herself. She is not afraid. She does not evade difficult tasks by transferring them to others, or by leaving them undone.

The student enters her work with much interest and youthful enthusiasm. This is priceless to the patient, to the hospital, to society, and to the nurse herself. It must not be lost. It will be lost, however, if she is not taught to use this interest and enthusiasm in the development of herself in her service. One of the great duties of the supervisor is to direct these qualities into the proper avenues of self-expression.

The supervisors form the necessary connecting link between the instruction received in the class room and its application at the bedside of the patient: between hospital administration and co-operation, "between medical science and its actual application when related to the patient." In other words, a supervisor is a teacher who helps. She is the connecting link between science and art; she keeps the balance between theory and practice.

3. *Nurses' records on patients in many instances are useless. What are the essentials of such records, and how can they be made of greater use?*

Miss Katherine Tucker, Superintendent, Visiting Nurse Society of Philadelphia: Certainly there can be little difference of opinion as to the fact that most nurses' records are useless, and therefore the real point of interest is why they are useless and what can be done about it. Too often the records are an expression of the opinions of the nurse and not an accurate statement of her observation of objective facts. Furthermore, the facts noted are the least essential while the truly significant ones may be given a superficial and inadequate description. For instance, the mere statement that a patient had a pain in his side or suffered from a chill leaves unnoted the really important point as to the exact place and nature of the pain and the kind of chill.

Granting the unsatisfactoriness of the present situation, what are the elements considered essential for a complete nurse's record? We can rather take for granted the clinical chart which gives a graphic presentation of the temperature, pulse, and respiration, with a numerical statement of the output and intake, details and description of which should appear in the nurse's notes. The important question, therefore, is what the notes should contain. These should give an accurate description of the patient's objective symptoms with a definite statement of the exact treatment given by the nurse and the patient's responses to such treatment. They should also include a brief statement of other occurrences that might affect the patient's condition. These statements should

not be matters of opinion but a careful description of facts.

Such records will not be easy to procure as nurses as a rule are not articulate in words, being chiefly expressive through their hands. It is necessary therefore to consider whether it is important to have such records and if so, how they can be acquired. They really are of primary importance to the patient as they assure him of the most careful consideration of all that might have bearing on his case. They should be essential to the doctor as developments might occur during his absence of which he cannot be aware except through the nurse's written record. She herself might not remember each significant detail unless she wrote it down. Furthermore, they are of importance to the doctor as a memorandum for future reference. The nurse also would benefit largely from such records as it would increase her interest in the patient and give added importance to her care of each case which would tend to make her more observant and have a tremendous educational value, helping her to correlate theory and practice, thus giving her a more intelligent understanding of her case. If these records are kept as described they should have a scientific value that cannot be overlooked and would contribute to the sum total of our knowledge of disease.

The real question is whether such records can be procured. To my mind the answer is that they can and should be procured; this, however, presupposes a broad foundation. No nurse could keep such records unless she were possessed of a fundamental intelligence and a sound preliminary education, preferably 4 years of high school. Added to this she must have a scientific knowledge which will teach her how to observe. This in turn involves sound teaching during her nursing training. In other words, the whole question of accurate nurses' records which are the right of the patient and should be a necessity to the doctor goes back to the type of woman we must get into our training schools and the kind of teaching we give her when she is there.

4. *What constitutes competent and sound applied nursing service in our hospitals today?*

Miss Mary M. Riddle, Superintendent, Newton Hospital, Newton Lower Falls, Massachusetts: One might say, that nursing service which helps the patients back to normal physical conditions and insures their ability to continue the ordinary pursuits of life and promote their happiness as well as general welfare, must be the soundest applied nursing service our hospitals can furnish today. And that hospital which recognizes these great obligations will lose no opportunity for acquiring equipment, knowledge, and the spirit to render it. Whether the nursing service is given by thoroughly trained and accomplished nurses or by a school of nursing which is an integral part of the hospital, it must be competent or the hospital does not meet its obligation to the patient. When the hospital is dependent upon its school of nursing for all or nearly all of the nursing care given to its inmates, it becomes necessary that the school shall have thorough instruction and competent supervision. If all other things were equal, one would say, or at least naturally suppose, that the best instruction would be given in the largest general hospitals. But since they are not equal, the best instruction is not always given there, though the material for teaching purposes is most abundant.

If the nursing body is accomplished and if the morale is what it should be, if there is enthusiasm for the work, conscientiousness in doing it, and a spirit of humanitarianism manifested or at least possessed by the nurse caring for the patient, whether the nursing service is rendered by pupils or graduates, it must pass into good care. In those institutions where the nursing care has always been given mainly by the pupils or a school of nursing, it has been the custom formerly to expect the most inexperienced beginners to undertake even complex work for the patients, who from the nature of their illness, should have had tender and skilful care and management. All that is now changed, it being the custom in those same schools to have the nurses made familiar with such procedures in the class room before coming in contact with the patients. This change is one of the blessings that have come out of the three years' course, advocates of which believe that practices should be so often repeated as to be done automatically and almost perfectly before the patient is subjected to them, and not only is a patient's comfort an item for consideration in this connection but his safety also, for when the nurse's routine practice is so nearly perfect, she need not concentrate her attention upon it but can keep her mind constantly upon the patient and his condition and thus often protect him from extreme weariness or even a much more serious situation that would really pass unnoticed if she were absorbed by her practice.

The patient should be given the best possible care at the hospital because, first, he needs it, and second, because the hospital by becoming such has positively agreed to give it. So far as the individ-

ual patient is concerned, the purpose is that he may be cured. But so far as the physicians, internes, and student nurses are concerned, there is an additional reason. That is, giving the care as thoroughly and scientifically as possible in order that other patients, future generations of patients anywhere and everywhere, may also have the benefit of their work. Besides the duty of the hospital in furnishing means for the possible cure of its patients, there is another duty it owes the public, and it may be classed under the head of prevention of the spread of disease. To this end it must then so use and suit the materials found in its walls that it can make its contribution to the sick. No small part of the additional work incurred in these procedures necessarily falls upon the nursing staff and it must be prepared for its work by being given suitable instruction. Here, again, may be mentioned another reason for the existence of the three years' course in the training school for nurses since suitable instruction in this as in all other forms of education requires time.

The arousing of the hospital and its staff through the hospital standardization campaign has borne much fruit, and that such efforts at improvement will have a stimulating effect upon the body of graduate nurses and nurse schools in all such institutions is firmly believed. Especially will it be so in those institutions where the student body of nurses is given recognition as an educational factor and where the school is supported, as it should be, by the hospital staff and community and standardization committee, all for the betterment of the sick.

It is believed, to recapitulate, that nursing service is best which contributes most to the ultimate recovery of the patient or, when recovery is impossible, which finds the patient every available comfort. It is believed that the most satisfactory nursing is done in the larger general hospitals and in those of secondary size by students of a well-equipped, well-managed, and well-instructed school of nurses. The old hospital slogan that "Nurses are created for the patients," must be amended to read, "for these and future patients, anywhere and everywhere, as well as for those whom we can help to avoid being patients." The nurses, therefore, must be trained to meet all such requirements, and 3 years are none too long for the purpose. It is the duty of the hospital to see that the student nurses get a just return for their efforts in its behalf. It is the nurse's duty, as well as privilege, to give her very best service to the patients and to carry out zealously all orders or directions for their care and treatment. If standardization does as much for the schools of nursing as it has done for the hospitals, it will certainly be welcomed by the schools.

The greatest need in the suffering world today is for young women of good breeding, of good education, and of fixed principles of righteousness, which when added to good training will make an army that will be invincible before selfishness, negligence, and profiteering.

Let the hospitals give them what they seek. Let the community give them a place in it. Let them be honored, let them be crowned with honor, and the dearth of them will disappear.

AN INEVITABLE REFORM IN NURSING

By NORMAN BRIDGE, M.D., New York

THE movement to train women for expert nursing began in this country five decades ago. Now practically every hospital has a training school. The standards for graduation from these schools have risen from time to time, and the result today is that our trained nurses are a body of superior and well educated women. Moreover, they have become a profession, and they have associations for the good of themselves and the public. In this particular the nurses have had the laudable example of the medical profession, with its many useful organizations.

The nursing guilds have become powerful politically. Many states have passed laws for their benefit and for the regulation of their work, but in some instances to the harm of both the public and the nurses themselves.

The nursing profession had an honorable, even heroic, part in the Great War. Many nurses attained rank in the Army, and familiarity with the work of the war nurses can only make one feel that all honors they received were well earned. Their work in the Red Cross has been and continues to be a credit to American womanhood.

As organized visiting nurses in sanitation and preventive medicine, they have taught many communities a new and epoch-making gospel of health, resulting in a distinct falling of the death rate. Let us not forget that to lengthen the average span of human life is the basic purpose of all our professions, of all doctors and of all nurses alike.

The profession of nursing has brought us, with all its good, some unfortunate tendencies. The increasing cost of the services of the trained nurse tends to restrict her work to the rich. It is impossible for poor people, and nearly impossible for those of moderate means, to have such expensive nursing for any length of time. This situation is against public policy and harmful to the best interests of society. It has become a public hardship so severe as to demand a change and an addition to the nursing service of the nation.

Relief must be found in some way. We need to get back to the simple life, both for the well and the sick. We must lessen our costly, spurious, and fastidious needs—learn contentment in simple foods, clothing, and equipages, and give good care to the sick in a less expensive way. Here is a commendable reform that is possible; and the nursing profession can and ought to help in its consummation.

The best method in sight is to raise the profession of trained nursing to a new dignity; and arrange for under-nurses, cadets, or sub-nurses, more or less under the direction of the highly trained ones. These new nurses should cost in fees not more than half what high training now requires, and they can be taught in a few weeks to do the major part of nursing in the average cases where little special skill is required. It ought to become the high privilege of the trained nurses to restrict their work as far as possible to those cases and those things requiring skill and professional thinking, while the cadets do much of the routine work, and perform many of the routine ministrations for the comfort of the patients.

Most well-to-do people will prefer the best trained, and most refined and agreeable nurses in all their invalidism. Such is their privilege and they are able, if not willing, to pay for it. The trained nurse will and should cultivate such patronage and command her proper fee. Rich patients are few, however. The multitude of poor people are all deserving, and some provision must be made for them.

A girl of intelligence and refinement with a primary school education can be taught in a few weeks to do most of the nursing in simple and plain cases. For practical things and emergent purposes, one of the best kinds of training is intensive training. The War has revealed in a surprising way the value of intensive training. Fighting aviators have been turned out in two or three months, and thousands of auto drivers of the highest skill in less time; farmer boys have been made into successful engineers' assistants for battleships in six weeks; and aids quickly trained in biological and medical laboratories. Why not provide such training in the fundamentals of nursing? Many young women during the War and during the influenza epidemic received a measure of intensive training in simple nursing, and did commendable and much needed service to the sick and injured.

The new nurses will quickly learn skill in observing the facts about the sick, and in recording them accurately—such as the pulse, respiration, temperature, food, sleep, excretions, and the like. They will learn to prepare foods and drinks,

to give medicines in manifold ways, to give baths and fomentations, and to attend to all the ministrations for comfort that even fastidious patients demand.

They should be, from their selection at the beginning, girls with ladylike ways, needing little teaching in circumspection and conduct. You cannot make a good nurse out of a girl who lacks the instincts of essential refinement; but there is no dearth of young women in this country who are naturally refined and quick to learn, and who would be glad to embark on an adventure so fascinating, so useful, and creditable.

The new nurse will (even more readily than a better educated woman) learn to obey precisely the orders of the doctor, without question or comment. Her small knowledge of anatomy, physiology, chemistry, and physics will help her to avoid the pretence of having valuable medical knowledge.

The sick man often—the sick woman perhaps more often—is prone to ask the nurse many questions that should only go to the doctor, and many questions that only The Almighty could answer finally. It takes courage for the nurse, as well as the doctor, to say "I don't know," and so the trained nurse is often betrayed into making statements to the patient that unsettle his mind and lessen his faith in his doctor's knowledge and standing. The sub-nurse will be less exposed to such temptations, and will more easily escape this sort of mischief.

Another thing which should be held out to the sub-nurse for her encouragement is the hope of promotion by constant efficiency and good behavior as well as by self-improvement. A cadet nurse should feel the possibility of sometime attaining the full honors of trained nursehood with all its emoluments. Not all men and women, great in expert things, have come up through the schools and colleges. Men have even attained the chief command of the Nation's armies who have never studied at West Point, for example, the late beloved Chaffee and the present Governor General of the Philippines.

This movement for less expensive nursing is parallel to the one for cheaper hospital services for the same class of people, and that class is the vast majority. These movements are alike worthy and they are bound to succeed.